DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/18/15

PRINTED: 06/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445216	A. BUILDING _____ B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINTREE MANOR	416 PACE STREET MC MINNVILLE, TN 37110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Recertification survey and investigation of complaint numbers 34457, 35660 and 31731, conducted on June 3, 2015, at Raintree Manor, no deficiencies were cited in relation to the complaints under 42 CFR PART 483, Requirements for Long Term Care.	F 000		6/19/15
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide the most recent state survey results in a readily accessible location for all residents in the facility. The findings included: Observation on 6/1/15, at 10:15 AM, of the facility's posting titled, State Survey Results, located in the glass display of the facility's lobby revealed "Copies of the most recent State Survey can be found in the Lobby, East and West Nurses Station, the Dir [Director] of Nursing's office and Administrator's office..."	F 167	**Disclaimer** **This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** **taken:** **F167 483.10(Survey Results Readily accessible** **1. The Administrator placed a binder with the survey results in the lobby on 6/1/15 .** **The Nursing supervisor placed a binder with survey results at the west nurses station on 6/1/15.** **2. No resident was affected by this alleged deficient practice.** **3. On *6/3/2015* the administrator provided education to the front office staff and the facility management team on F-167 resident rights to survey results. On 6/3/2015 The administrator revised the notice and the location of the survey results. The binder was secured to the wall with a chain to prevent the removal of the binder.**	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6/19/15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that hor safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 167	Continued From page 1 Observation on 6/1/15, at 10:15 AM, revealed the survey results could not be located in the lobby. Observation on 6/1/15, at 10:22 AM, revealed the survey results could not be located at the West Nurses Station. Interview with Licensed Practical Nurse #2 (LPN) on 6/1/15 at 10:25 AM, at the West Nurses Station, confirmed, "The survey results are not here on the west station right now." Interview with LPN #1 on 6/1/15 at 10:29 AM, at the West Nurses Station, confirmed, "There are no survey results in the lobby." Interview with LPN #2 on 6/1/15 at 10:38 AM, in the conference room, confirmed the state survey results were not located in the areas specified on the State Survey Result document located in the lobby.	F 167	**The management team or designee will monitor the designated location of the binder 5 x week X 4 weeks then weekly X 8 weeks or until sustained compliance can be achieved during environmental rounds to ensure the binder is readily accessible.** **4. The Administrator will report findings to the Quality Assurance Performance Improvement committee monthly for three months and then PRN. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Director of Social Services, Dietary Manager, Minimum Data Set Coordinator and Medical Director.**	6/19/15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F 441 483.65 Infection Control, Prevent Spread , Linens** **1. On 6/3/15 the Regional Director of Clinical Services provided one on one education to the staff member on hand Hygiene Policy, Infection Control** **2. No resident was affected by this alleged deficient practice.** **3. On 6/3/15 the Assistant Director of Nursing and the Nursing Supervisor provided re-education to all nursing staff on Hygiene Policy, Infection Control**	6/19/15

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F 441	Continued From page 2 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation, and interview, the facility failed to maintain an infection control program to ensure meals were distributed in a sanitary manner for 1 of 3 dining areas observed. The findings included: Review of the facility's policy (undated) Infection Control Standard Precautions revealed, "...Perform appropriate hand hygiene...between resident contact, and otherwise indicated to avoid transfer of microorganisms to other residents or	F 441	**The Director of Nursing or designee will monitor all meal services daily for two weeks and then monthly for two months and PRN to ensure meals are distributed in a sanitary manner.** **4. The Director of Nursing will report findings to the Quality Assurance Performance Improvement committee monthly for three months and then PRN. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Director of Social Services, Dietary Manager, Minimum Data Set Coordinator and Medical Director.**	

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F 441	Continued From page 3 environments. Perform appropriate hand hygiene between tasks..." Observation on 6/1/15 at 11:50 AM, in the Main Dining Hall, revealed a staff member scratched her nose, repositioned a resident's feet on wheelchair foot rests with bare hands and then filled a resident's beverage cup with ice without sanitizing the hands. Continued observation on 6/1/15 at 11:51 AM, in the Main Dining Hall, revealed the same staff member scratched her nose and delivered eating utensils to the residents sitting at the tables in the Main Dining Hall without sanitizing the hands. Observation on 6/2/15 from 11:56 AM through 11:59 AM, in the Main Dining Hall, revealed the same staff member performed the following tasks: changed the compact disk (CD) on the audio equipment and scratched her head with bare hands; filled a beverage cup with ice without the sanitizing hands; scratched her nose and filled a beverage cup with ice with bare hands without sanitizing the hands; picked her ear with a bare finger, repositioned a resident with bare hands, and filled a beverage cup with ice without sanitizing the hands. Interview with the Director of Nursing (DON) on 6/3/15 at 8:40 AM, in the DON office, confirmed the facility failed to follow their Infection Control Standard Precautions Policy for hand hygiene during the meal distribution.	F 441		